Appendix 6

HCFA-486 Form

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0357

MEDICAL UPDATE AND PATIENT INFORMATION

1. Patient's HI Claim No.	2. SOC Date	3. Certification Period From: To:	4. Medical Record No.	5. Provider No.

6. Patient's Name and Address

7. Provider's Name

8. Medicare Covered: ☐ Y ☐ N

9. Date Physician Last Saw Patient:

10. Date Last Contacted Physician:

11. Is the Patient Receiving Care in an 1861 (J)(1) Skilled Nursing Facility or Equivalent? ☐ Y ☐ N ☐ Do Not Know

12. ☐ Certification ☐ Recertification ☐ Modified

13. Dates of Last Inpatient Stay: Admission Discharge

14. Type of Facility:

15. Updated information: New Orders/Treatments/Clinical Facts/Summary from Each Discipline

16. Functional Limitations (Expand From 485 and Level of ADL) Reason Homebound/Prior Functional Status

17. Supplementary Plan of Care of File from Physician Other than Referring Physician: ☐ Y ☐ N
(If Yes, Please Specify Giving Goals/Rehab. Potential/Discharge Plan)

18. Unusual Home/Social Environment

19. Indicate Any Time When the Home Health Agency Made a Visit and Patient was Not Home and Reason Why if Ascertainable

20. Specify Any Known Medical and/or Non-Medical Reasons the Patient Regularly Leaves Home and Frequency of Occurrence

21. Nurse or Therapist Completing or Reviewing Form

Date (Mo., Day, Yr.)

PROVIDER

Form HCFA-486 (C3) (02-94)